

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01851

1876

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville				c. LENGTH OF STAY IN 1b 35 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Etta Middle C. Last Summers Baker				4. DATE OF DEATH Month 2 Day 7 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Summers				14. MOTHER'S MAIDEN NAME Mary Ellen Harshman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Frank Baker, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized arteriosclerosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12 , 19 59 , to Feb 7 , 19 59 , that I last saw the deceased alive on Feb 7 , 19 59 , and that death occurred at 4:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro - DATE SIGNED 2/9/59 ACTUAL SIGNATURE G. W. Levan M.D. PHYSICIAN'S NAME (Type) Dr. Gerald Levan Boonsboro, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/10/1959		22c. NAME OF CEMETERY OR CREMATORY Ch. of B. Cemetery		22d. LOCATION (City, town, or county) (State) Harmony, Fredk. co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE FEB 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1877

CERTIFICATE OF DEATH

01852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#3		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Yellow Springs		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE WASHINGTON BARTGIS		4. DATE OF DEATH Month Day Year February 19, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mathias Bartgis		14. MOTHER'S MAIDEN NAME Georgianna Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. P	
17. INFORMANT Mr. Luther Bartgis-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with wide spread metastases 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1 , 19 58 , to 2-19 , 19 59 , that I last saw the deceased alive on 2-16 , 19 59 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Rex R. Martin		ADDRESS (Street, city or town, state) East Church Street	
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		DATE SIGNED 2/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1900"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF DEATH [Faint text, possibly "11-1-1945"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MEDICAL ATTENDANCE [Faint text, possibly "Physician"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"]		SIGNATURE OF CORONER [Faint text, possibly "John Doe"]	
SIGNATURE OF JURY [Faint text, possibly "John Doe"]		SIGNATURE OF JUDGE [Faint text, possibly "John Doe"]	
SIGNATURE OF CLERK [Faint text, possibly "John Doe"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1878

CERTIFICATE OF DEATH

Reg. Dist. No.

01853

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson-Rural-R.D.#1				c. LENGTH OF STAY IN 1b 31 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Poffenberger Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle STEPHEN Last BISER				4. DATE OF DEATH Month February Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1887	
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Owner			
13. FATHER'S NAME Henry Clagett Biser				14. MOTHER'S MAIDEN NAME Eliza E. A. V. Bowlus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-36-0355		17. INFORMANT Mrs. Ethel R. Biser-Same as item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decomposition 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile Dementia DUE TO (c) Marked Generalized Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 mo 2 y 20			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1958 , to Feb 24, 1959 , that I last saw the deceased alive on Feb 24, 1959 , and that death occurred at 3:40 P. M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Jefferson, Maryland			
ACTUAL SIGNATURE C. D. Brice M.D.				DATE SIGNED 2/25/59			
PHYSICIAN'S NAME (Type) Dr. A. T. Brice							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27, 1959		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Jefferson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR MAR 2 '59		24b. REGISTRAR'S SIGNATURE Colton S. Kraus	

8582

1879

CERTIFICATE OF DEATH

01854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R#5, Frederick</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick County Chronic Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DANIEL</u> First <u>Thomas - DANIEL</u> Middle <u>Blackston</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>m.</u>		6. COLOR OR RACE <u>c.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/18/83</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		IF UNDER 24 HRS. Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Co., Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>DANIEL BLACKSTON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH James Prater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Ruth Crawford Rn. Supt. Chronic Hosp.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>3 yr.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 23, 1959</u> to <u>Feb. 23, 1959</u> , that I last saw the deceased alive on <u>Feb. 23, 1959</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. Kline</u>				DATE SIGNED <u>Feb. 23, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Dr. H. F. Kline</u>				ADDRESS (Street, city or town, state) <u>7711 Montrose St. Frederick Md 21701</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>Della - Fred. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>				24. REC'D BY REGISTRAR <u>AR 2 '59</u>			
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01855

1847

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE		b. COUNTY	
Frederick				Maryland		Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Frederick		Life		Frederick					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
129 A West 4th Street				129A West 4th Street					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year			
Lillie Fogle Boyer				February 18 19 59					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White				August 8, 1888		69 70 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housekeeper		none		Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Grant Fogle		Malinda May Eyer							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		214-10-4070		Mrs. Charles L. Thompson		Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per type for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		b. DUE TO		c. DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
420.1		Due to		Ch. Charles R. R. P. Tucker		1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						10 3/4			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that I attended the deceased from 6-1 1949, to 2-18 1959, that I last saw the deceased alive on 2-18-59, 19, and that death occurred at 8:30 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE		M.D.		DATE SIGNED					
H. J. Bourne Jr.		Frederick, Maryland							
PHYSICIAN'S NAME (Type)		U.S. Bourne, Jr.		M.D. Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		2/20/59		Glade Cemetery		Walkersville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Robert E. Bailey		Frederick, Maryland		DATE 2-20-59					

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAMES H. HARRIS		45		M		W		1878		BALTIMORE		MD		U.S.A.		JAN 15 1923		BALTIMORE		MD		U.S.A.	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S DEATH DATE		MOTHER'S DEATH DATE	
JAMES H. HARRIS		JANE H. HARRIS		Carpenter		Homemaker		Protestant		Protestant		High School		High School		Married		Married		1895		1915	
DECEASED'S OCCUPATION		DECEASED'S RELIGION		DECEASED'S EDUCATION		DECEASED'S MARITAL STATUS		DECEASED'S DEATH CAUSE		DECEASED'S DEATH PLACE		DECEASED'S DEATH CITY		DECEASED'S DEATH COUNTRY		DECEASED'S DEATH DATE		DECEASED'S DEATH PLACE		DECEASED'S DEATH CITY		DECEASED'S DEATH COUNTRY	
Carpenter		Protestant		High School		Married		Heart Disease		BALTIMORE		MD		U.S.A.		JAN 15 1923		BALTIMORE		MD		U.S.A.	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTRY		DECEASED'S ZIP CODE		DECEASED'S PHONE NUMBER		DECEASED'S FAX NUMBER		DECEASED'S TELETYPE NUMBER		DECEASED'S RADIO NUMBER		DECEASED'S TELEVISION NUMBER		DECEASED'S OTHER NUMBER	
JAMES H. HARRIS		1234 E. BALTIMORE ST.		BALTIMORE		MD		U.S.A.		21201		(410) 555-1234											
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTRY		DECEASED'S ZIP CODE		DECEASED'S PHONE NUMBER		DECEASED'S FAX NUMBER		DECEASED'S TELETYPE NUMBER		DECEASED'S RADIO NUMBER		DECEASED'S TELEVISION NUMBER		DECEASED'S OTHER NUMBER	
JAMES H. HARRIS		1234 E. BALTIMORE ST.		BALTIMORE		MD		U.S.A.		21201		(410) 555-1234											
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTRY		DECEASED'S ZIP CODE		DECEASED'S PHONE NUMBER		DECEASED'S FAX NUMBER		DECEASED'S TELETYPE NUMBER		DECEASED'S RADIO NUMBER		DECEASED'S TELEVISION NUMBER		DECEASED'S OTHER NUMBER	
JAMES H. HARRIS		1234 E. BALTIMORE ST.		BALTIMORE		MD		U.S.A.		21201		(410) 555-1234											

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Carrie May Hallman-Alias-Brown</u>				4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-23-1905</u>	
9. AGE (In years last birthday) <u>53 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? 							
13. FATHER'S NAME <u>John A. Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Maggie L. Dillard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-24-8872</u>		17. INFORMANT Address <u>Mary Wilson - 22 S. Court Street Fred, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Cerebral infarction</u> DUE TO (b) <u>Hypertension, benign essential</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-1-1959</u> , to <u>2-19-1959</u> , that I last saw the deceased alive on <u>2-18-1959</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rex R Martin</u> M.D.				ADDRESS (Street, city or town, state) <u>35 E Church Frederick Md</u> DATE SIGNED <u>2-20-59</u>			
PHYSICIAN'S NAME (Type) <u>Rex R Martin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles E. Hicks 111 Frederick, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1232

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>Johns Hopkins</u></p>	
<p>5. Date of death: <u>Dec 1, 1950</u></p>		<p>6. Place of death: <u>Johns Hopkins</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Signature of informant: <u>John Doe</u></p>		<p>12. Signature of witness: <u>John Doe</u></p>	
<p>13. Signature of funeral director: <u>John Doe</u></p>		<p>14. Signature of undertaker: <u>John Doe</u></p>	
<p>15. Signature of coroner: <u>John Doe</u></p>		<p>16. Signature of jury: <u>John Doe</u></p>	
<p>17. Signature of jury: <u>John Doe</u></p>		<p>18. Signature of jury: <u>John Doe</u></p>	
<p>19. Signature of jury: <u>John Doe</u></p>		<p>20. Signature of jury: <u>John Doe</u></p>	
<p>21. Signature of jury: <u>John Doe</u></p>		<p>22. Signature of jury: <u>John Doe</u></p>	
<p>23. Signature of jury: <u>John Doe</u></p>		<p>24. Signature of jury: <u>John Doe</u></p>	
<p>25. Signature of jury: <u>John Doe</u></p>		<p>26. Signature of jury: <u>John Doe</u></p>	
<p>27. Signature of jury: <u>John Doe</u></p>		<p>28. Signature of jury: <u>John Doe</u></p>	
<p>29. Signature of jury: <u>John Doe</u></p>		<p>30. Signature of jury: <u>John Doe</u></p>	
<p>31. Signature of jury: <u>John Doe</u></p>		<p>32. Signature of jury: <u>John Doe</u></p>	
<p>33. Signature of jury: <u>John Doe</u></p>		<p>34. Signature of jury: <u>John Doe</u></p>	
<p>35. Signature of jury: <u>John Doe</u></p>		<p>36. Signature of jury: <u>John Doe</u></p>	
<p>37. Signature of jury: <u>John Doe</u></p>		<p>38. Signature of jury: <u>John Doe</u></p>	
<p>39. Signature of jury: <u>John Doe</u></p>		<p>40. Signature of jury: <u>John Doe</u></p>	
<p>41. Signature of jury: <u>John Doe</u></p>		<p>42. Signature of jury: <u>John Doe</u></p>	
<p>43. Signature of jury: <u>John Doe</u></p>		<p>44. Signature of jury: <u>John Doe</u></p>	
<p>45. Signature of jury: <u>John Doe</u></p>		<p>46. Signature of jury: <u>John Doe</u></p>	
<p>47. Signature of jury: <u>John Doe</u></p>		<p>48. Signature of jury: <u>John Doe</u></p>	
<p>49. Signature of jury: <u>John Doe</u></p>		<p>50. Signature of jury: <u>John Doe</u></p>	
<p>51. Signature of jury: <u>John Doe</u></p>		<p>52. Signature of jury: <u>John Doe</u></p>	
<p>53. Signature of jury: <u>John Doe</u></p>		<p>54. Signature of jury: <u>John Doe</u></p>	
<p>55. Signature of jury: <u>John Doe</u></p>		<p>56. Signature of jury: <u>John Doe</u></p>	
<p>57. Signature of jury: <u>John Doe</u></p>		<p>58. Signature of jury: <u>John Doe</u></p>	
<p>59. Signature of jury: <u>John Doe</u></p>		<p>60. Signature of jury: <u>John Doe</u></p>	
<p>61. Signature of jury: <u>John Doe</u></p>		<p>62. Signature of jury: <u>John Doe</u></p>	
<p>63. Signature of jury: <u>John Doe</u></p>		<p>64. Signature of jury: <u>John Doe</u></p>	
<p>65. Signature of jury: <u>John Doe</u></p>		<p>66. Signature of jury: <u>John Doe</u></p>	
<p>67. Signature of jury: <u>John Doe</u></p>		<p>68. Signature of jury: <u>John Doe</u></p>	
<p>69. Signature of jury: <u>John Doe</u></p>		<p>70. Signature of jury: <u>John Doe</u></p>	
<p>71. Signature of jury: <u>John Doe</u></p>		<p>72. Signature of jury: <u>John Doe</u></p>	
<p>73. Signature of jury: <u>John Doe</u></p>		<p>74. Signature of jury: <u>John Doe</u></p>	
<p>75. Signature of jury: <u>John Doe</u></p>		<p>76. Signature of jury: <u>John Doe</u></p>	
<p>77. Signature of jury: <u>John Doe</u></p>		<p>78. Signature of jury: <u>John Doe</u></p>	
<p>79. Signature of jury: <u>John Doe</u></p>		<p>80. Signature of jury: <u>John Doe</u></p>	
<p>81. Signature of jury: <u>John Doe</u></p>		<p>82. Signature of jury: <u>John Doe</u></p>	
<p>83. Signature of jury: <u>John Doe</u></p>		<p>84. Signature of jury: <u>John Doe</u></p>	
<p>85. Signature of jury: <u>John Doe</u></p>		<p>86. Signature of jury: <u>John Doe</u></p>	
<p>87. Signature of jury: <u>John Doe</u></p>		<p>88. Signature of jury: <u>John Doe</u></p>	
<p>89. Signature of jury: <u>John Doe</u></p>		<p>90. Signature of jury: <u>John Doe</u></p>	
<p>91. Signature of jury: <u>John Doe</u></p>		<p>92. Signature of jury: <u>John Doe</u></p>	
<p>93. Signature of jury: <u>John Doe</u></p>		<p>94. Signature of jury: <u>John Doe</u></p>	
<p>95. Signature of jury: <u>John Doe</u></p>		<p>96. Signature of jury: <u>John Doe</u></p>	
<p>97. Signature of jury: <u>John Doe</u></p>		<p>98. Signature of jury: <u>John Doe</u></p>	
<p>99. Signature of jury: <u>John Doe</u></p>		<p>100. Signature of jury: <u>John Doe</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01857

1880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson-Rural RD#1 c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jefferson-Burkittsville Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson-Rural RD#1 d. STREET ADDRESS Jefferson-Burkittsville Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VIOLA Middle LOUISE Last BRUBAKER		4. DATE OF DEATH Month February 6, Day 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Nov 1897
9. AGE (In years lost birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel W. Brown		14. MOTHER'S MAIDEN NAME Emma Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Luther R. Brubaker (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cerebral Vascular Disease 18 years DUE TO Generalized Arteriosclerosis (c) Specialized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5, 1959 to Feb 6, 1959 that I last saw the deceased alive on Feb 5, 1959 and that death occurred at 11:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jefferson, Md. DATE SIGNED 9 Feb 1959			
ACTUAL SIGNATURE A. T. Brice M.D.		PHYSICIAN'S NAME (Type) A. T. Brice, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-59	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Jefferson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR FEB 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1881

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>			
c. LENGTH OF STAY IN 1b <u>YEARS</u>				d. STREET ADDRESS <u>ROUTE I</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROUTE I</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES EDWARD BRUCHEY</u>				4. DATE OF DEATH Month Day Year <u>FEB 6 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/1885</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH FARM MACH.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE W. BRUCHEY</u>				14. MOTHER'S MAIDEN NAME <u>GEORGIANNA HARGETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. CARRIE M. BRUCHEY, FREDERICK ROUTE I MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular disease</u> DUE TO <u>arteriosclerosis, hypertension</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>59</u> , to <u>Feb 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 5</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>FREDERICK, MD</u> DATE SIGNED <u>FEB 6, 1959</u>							
ACTUAL SIGNATURE <u>B. B. Thomas</u> M.D. <u>FREDERICK, MD</u>							
PHYSICIAN'S NAME (Type) <u>B. B. Thomas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM CEM</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler & Sons, Quarrytown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1849
CERTIFICATE OF DEATH

Reg. Dist. No.

01859

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 East Third Street		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 312 East Third Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First BERTHA Middle ELIZABETH Last BURDETTE		4. DATE OF DEATH Month February Day 28, Year 19 59				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Sulcer			14. MOTHER'S MAIDEN NAME Catherine Hale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-0301		17. INFORMANT Mrs. Bernard T. Hiltner-Same as item #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① 7 hr 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ② Diabetes mellitus DUE TO (c) ③ Hypertensive arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4-5 days years years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-1 , 19 53 to 2-28 , 19 59 , that I last saw the deceased alive on 2-27 , 19 59 , and that death occurred at 11:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 3/2/59 ACTUAL SIGNATURE Rex R. Martin M.D. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin Frederick, Maryland						
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE MAR 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G239 3-2-59 et

CERTIFICATE OF DEATH

1850

01860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 602 E Patrick Street Frederick Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Grossnickle Burnett				4. DATE OF DEATH Month Day Year February 21, 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 19, 1884	
9. AGE (In years last birthday) 75 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leonard Grossnickle	
14. MOTHER'S MAIDEN NAME Mary Renner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 336-18-9752		17. INFORMANT Mrs. Roy Putman	
Address 602 E. Patrick St. Frederick, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 wks. 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Jan 29 , 19 57 , to Jan 29 , 19 59 , that I last saw the deceased alive on Jan 29 , 19 59 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. F. Kline M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Frederick Md Feb 21 59			
PHYSICIAN'S NAME (Type) Dr. H. F. Kline				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Feb. 24-1959		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown Maryland		24a. REC'D BY REGISTRAR FEB 25 59	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Bailey				ADDRESS 1201 N. Market St. Frederick Maryland		24b. REGISTRAR'S SIGNATURE Robert S. Bailey	

CERTIFICATE OF DEATH

NAME OF DECEASED [Name]		SEX [Sex]		AGE [Age]		DATE OF BIRTH [Date]	
PLACE OF BIRTH [Place]		OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]	
DATE OF DEATH [Date]		TIME OF DEATH [Time]		PLACE OF DEATH [Place]		COUNTY [County]	
CITY [City]		STATE [State]		ZIP CODE [ZIP]		REGISTRAR [Registrar]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
DATE OF SIGNATURE [Date]		DATE OF SIGNATURE [Date]		DATE OF SIGNATURE [Date]		DATE OF SIGNATURE [Date]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1851

CERTIFICATE OF DEATH

Reg. Dist. No.

01861

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>J. M. H.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Carroll</u> Last <u></u>				4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/59</u>	9. AGE (In years last birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick - Md.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Donald Ohrem</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Dorothy Carroll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-18</u> , 19 <u>59</u> , to <u>2-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-19</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Fred J. Helorich</u>				M.D. <u>220 N. Market</u>			
PHYSICIAN'S NAME (Type) <u>FRED J. HELORICIF</u>				<u>Frederick, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS III</u>				ADDRESS <u>Fred. - Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraus</u>

2069307XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01862

1852

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Exie Middle Alva Last Carter				4. DATE OF DEATH Month Feb. Day 27 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1890	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 6 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Knoxville, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George M. Merriman				14. MOTHER'S MAIDEN NAME Alice Jane Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Richard T. Carter 12 South Maple Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) yes INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatectomy + vagina esurg. repair 7 days 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/21/59 , 19 59 , to 2/27/59 , 19 59 , that I last saw the deceased alive on 2/27/59 , 19 59 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 W 3rd St Fred. DATE SIGNED 2/28/59							
ACTUAL SIGNATURE Frank Damazo M.D.				PHYSICIAN'S NAME (Type) FRANK DAMAZO			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 2, '59		22c. NAME OF CEMETERY OR CREMATORY Church of Brethern	
22d. LOCATION (City, town, or county) Brownsville Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Elva V. Fester ADDRESS Brunswick, Md.				24a. REC'D BY REGISTRAR DATE MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF MINISTER [REDACTED]		NAME OF FUNERAL HOME [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	
NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF MINISTER [REDACTED]		NAME OF FUNERAL HOME [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	
NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF MINISTER [REDACTED]		NAME OF FUNERAL HOME [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1882

CERTIFICATE OF DEATH

Reg. Dist. No.

01863

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 157 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hosp.				d. STREET ADDRESS Damascus			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Elizabeth CHANEY				4. DATE OF DEATH Month February Day 8 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1905	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse				10b. KIND OF BUSINESS OR INDUSTRY Medica 1		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William J. Chaney				14. MOTHER'S MAIDEN NAME Betty Hillard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 579-09-4478		17. INFORMANT Hospital Chart (Patient)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis 002 X DUE TO 'Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 4, 1958 , to Feb. 8, 1959 , that I last saw the deceased alive on Feb. 7, 1959 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED T. F. Vestal February 8, 1959 M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) T. F. Vestal, M. D., Victor Cullen State Hosp. Cullen, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molnar Per L.K.F.				24a. REC'D BY REGISTRAR DATE FEB 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01864

1853

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB 2 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 323 Queen Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 323 Queen Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle LEE Last CRAMER		4. DATE OF DEATH Month February Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 July 1910
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Representative		10b. KIND OF BUSINESS OR INDUSTRY Oil Company	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert E. L. Cramer		14. MOTHER'S MAIDEN NAME Edna A. Reich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-3140	
17. INFORMANT Mrs. Nina A. Cramer (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with acute myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1- , 19 57 , to 2-2- , 19 59 , that I last saw the deceased alive on 1-31- , 19 59 , and that death occurred at 10:30A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church St. DATE SIGNED 2 Feb 1959			
ACTUAL SIGNATURE Rex R. Martin M.D.		PHYSICIAN'S NAME (Type) Rex R. Martin, M. D. Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-59	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR FEB 4 '59		24b. REGISTRAR'S SIGNATURE William S. Knaus	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01865

1883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville-Rural-R.D.#1	c. LENGTH OF STAY IN 1b 5 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville-Rural-R.D.#1,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Petersville		e. STREET ADDRESS Near Petersville	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FRANKLIN Last CRAMER		4. DATE OF DEATH Month February Day 9, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 9, 1906
9. AGE (in years and birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Man		10b. KIND OF BUSINESS OR INDUSTRY Ultra Life Lab.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Henry Cramer	
14. MOTHER'S MAIDEN NAME Emma Catherine Shank		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220-03-9949		17. INFORMANT Mrs. Virginia L. Cramer, Same as item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide poisoning 9731 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fasten Hose on Tail Pipe of Auto	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. B. O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1884

CERTIFICATE OF DEATH

01866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>RAY</u> Last <u>CROMWELL</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 2, 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		11. BIRTHPLACE (State or foreign country) <u>Fred. Co. Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Milling Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Fred. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Arthur H. Cromwell</u>	
14. MOTHER'S MAIDEN NAME <u>Harriet Elizabeth Etzler</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-8072</u>		17. INFORMANT <u>Mrs Daisy Cromwell, Walkersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>5 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August</u> , 19 <u>54</u> , to <u>17 February</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>17 February</u> , 19 <u>59</u> , and that death occurred at <u>1:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Walkersville, Md</u>			
DATE SIGNED <u>2/19/59</u>				PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glade Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Walkersville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. O. Barton, Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
TIME OF DEATH _____		PLACE OF INTERMENT _____	
NAME OF PHYSICIAN _____		NAME OF FUNERAL HOME _____	
NAME OF WITNESS _____		NAME OF REGISTRAR _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
DATE _____		TIME _____	



1854

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital				e. STREET ADDRESS 204 Shipley Ave.			
3. NAME OF DECEASED (Type or print) Clark First Walden Middle Day Last				4. DATE OF DEATH Feb Month 8 Day 1959 Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Damascus, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Columbus W. Day				14. MOTHER'S MAIDEN NAME Addie Hobbs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 705-09-1623		17. INFORMANT Mrs Bessie E. Day, Mt. Airy, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure 420.0 DUE TO (b) Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Pneumonia, right lung 2) Chronic Bronchitis 3) Emphysema							INTERVAL BETWEEN ONSET AND DEATH 2 mo + 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/7 , 19 59 , to 2/8 , 19 59 , that I last saw the deceased alive on 2/8 , 19 59 , and that death occurred at 12:25 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Chase M.D.				ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 2/8/59			
PHYSICIAN'S NAME (Type) Henry V. Chase				Frederick Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molemanth ADDRESS Damascus, Md.				24a. REC'D BY REGISTRAR DATE FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 15 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Judy Diane Edmonds		4. DATE OF DEATH Month Day Year February 12, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1957
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Edmonds		14. MOTHER'S MAIDEN NAME Doris Barr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 916.0 Third Degree Thermal Burns DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) Older sibling accidentally set deceased's dress afire while playing with matches	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2.11. 1959 9:00		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Legore--Frederick--Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/59	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) Legore (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Y. C. Barton		ADDRESS Walkersville, Md.	
24a. REC'D BY REGISTRAR FEB 16 '59		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01869

1856

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>		d. STREET ADDRESS <u>638 N. Mulberry St</u>	
3. NAME OF DECEASED (Type or print) <u>Guy</u> First <u>Middleton</u> Middle <u>Elliott</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pattern Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sandblast machinery</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel B. Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bell High</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-0986</u>	
17. INFORMANT <u>Record of Victor Cullen Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO Pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>14 mos</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/26</u> , 19 <u>59</u> , to <u>2/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/15</u> , 19 <u>59</u> , and that death occurred at <u>10:50</u> P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>For T.F. [illegible]</u> <u>Michael G. Zaviss</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Victor Cullen State Hospital</u> <u>Cullen, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Michael G. Zaviss, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott J. Mennick & Son Hagerstown Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE			
JAMES H. HARRIS		65		M		W		JAN 15 1885		JAN 25 1950		HOME		BALTIMORE		BALTIMORE		MD			
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY		COUNTY	
MARRIED		JAN 15 1910		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
EDUCATION		SCHOOL		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		BUSINESS		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
BUSINESS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		HEART		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
HEART		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MANNER OF DEATH		NATURAL		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
NATURAL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		JAMES H. HARRIS		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
JAMES H. HARRIS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF REGISTRAR		JAMES H. HARRIS		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
JAMES H. HARRIS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1857

CERTIFICATE OF DEATH

Reg. Dist. No.

01870

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Frederick Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATIE Middle MAY Last MATILDA EYLER		4. DATE OF DEATH Month February Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 April 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lambert		14. MOTHER'S MAIDEN NAME Alice Batson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Raymond W. Eyler (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH months years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September, 1957 , to February, 1959 , that I last saw the deceased alive on 12 February, 1959 , and that death occurred at 4 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James B. Thomas		ADDRESS (Street, city or town, state) 228 N. Market St.,	
PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		DATE SIGNED 23 Feb 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-59	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Md.	
24a. REC'D BY REGISTRAR DATE FEB 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Signature of informant: _____</p>		<p>12. Signature of witness: _____</p>	
<p>13. Signature of funeral director: _____</p>		<p>14. Signature of undertaker: _____</p>	
<p>15. Signature of coroner: _____</p>		<p>16. Signature of medical examiner: _____</p>	
<p>17. Signature of health officer: _____</p>		<p>18. Signature of state health officer: _____</p>	
<p>19. Signature of state health officer: _____</p>		<p>20. Signature of state health officer: _____</p>	
<p>21. Signature of state health officer: _____</p>		<p>22. Signature of state health officer: _____</p>	
<p>23. Signature of state health officer: _____</p>		<p>24. Signature of state health officer: _____</p>	
<p>25. Signature of state health officer: _____</p>		<p>26. Signature of state health officer: _____</p>	
<p>27. Signature of state health officer: _____</p>		<p>28. Signature of state health officer: _____</p>	
<p>29. Signature of state health officer: _____</p>		<p>30. Signature of state health officer: _____</p>	
<p>31. Signature of state health officer: _____</p>		<p>32. Signature of state health officer: _____</p>	
<p>33. Signature of state health officer: _____</p>		<p>34. Signature of state health officer: _____</p>	
<p>35. Signature of state health officer: _____</p>		<p>36. Signature of state health officer: _____</p>	
<p>37. Signature of state health officer: _____</p>		<p>38. Signature of state health officer: _____</p>	
<p>39. Signature of state health officer: _____</p>		<p>40. Signature of state health officer: _____</p>	
<p>41. Signature of state health officer: _____</p>		<p>42. Signature of state health officer: _____</p>	
<p>43. Signature of state health officer: _____</p>		<p>44. Signature of state health officer: _____</p>	
<p>45. Signature of state health officer: _____</p>		<p>46. Signature of state health officer: _____</p>	
<p>47. Signature of state health officer: _____</p>		<p>48. Signature of state health officer: _____</p>	
<p>49. Signature of state health officer: _____</p>		<p>50. Signature of state health officer: _____</p>	
<p>51. Signature of state health officer: _____</p>		<p>52. Signature of state health officer: _____</p>	
<p>53. Signature of state health officer: _____</p>		<p>54. Signature of state health officer: _____</p>	
<p>55. Signature of state health officer: _____</p>		<p>56. Signature of state health officer: _____</p>	
<p>57. Signature of state health officer: _____</p>		<p>58. Signature of state health officer: _____</p>	
<p>59. Signature of state health officer: _____</p>		<p>60. Signature of state health officer: _____</p>	
<p>61. Signature of state health officer: _____</p>		<p>62. Signature of state health officer: _____</p>	
<p>63. Signature of state health officer: _____</p>		<p>64. Signature of state health officer: _____</p>	
<p>65. Signature of state health officer: _____</p>		<p>66. Signature of state health officer: _____</p>	
<p>67. Signature of state health officer: _____</p>		<p>68. Signature of state health officer: _____</p>	
<p>69. Signature of state health officer: _____</p>		<p>70. Signature of state health officer: _____</p>	
<p>71. Signature of state health officer: _____</p>		<p>72. Signature of state health officer: _____</p>	
<p>73. Signature of state health officer: _____</p>		<p>74. Signature of state health officer: _____</p>	
<p>75. Signature of state health officer: _____</p>		<p>76. Signature of state health officer: _____</p>	
<p>77. Signature of state health officer: _____</p>		<p>78. Signature of state health officer: _____</p>	
<p>79. Signature of state health officer: _____</p>		<p>80. Signature of state health officer: _____</p>	
<p>81. Signature of state health officer: _____</p>		<p>82. Signature of state health officer: _____</p>	
<p>83. Signature of state health officer: _____</p>		<p>84. Signature of state health officer: _____</p>	
<p>85. Signature of state health officer: _____</p>		<p>86. Signature of state health officer: _____</p>	
<p>87. Signature of state health officer: _____</p>		<p>88. Signature of state health officer: _____</p>	
<p>89. Signature of state health officer: _____</p>		<p>90. Signature of state health officer: _____</p>	
<p>91. Signature of state health officer: _____</p>		<p>92. Signature of state health officer: _____</p>	
<p>93. Signature of state health officer: _____</p>		<p>94. Signature of state health officer: _____</p>	
<p>95. Signature of state health officer: _____</p>		<p>96. Signature of state health officer: _____</p>	
<p>97. Signature of state health officer: _____</p>		<p>98. Signature of state health officer: _____</p>	
<p>99. Signature of state health officer: _____</p>		<p>100. Signature of state health officer: _____</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G238 2-11-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01871

1885

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN TB life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth K. Middle Fleagle Last		4. DATE OF DEATH Month Feb. Day 2 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878 Sept. 4, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Wireman		14. MOTHER'S MAIDEN NAME Virginia Flayharty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Thomas W. Lynn		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days 15 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 2, 1958 to Feb. 2, 1959 , that I last saw the deceased alive on Feb. 2, 1959 , and that death occurred at 2:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED 2/3/59 ACTUAL SIGNATURE M. Franklin Birely M.D. Thurmont, Md. PHYSICIAN'S NAME (Type) M. Franklin Birely			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-59	
22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Thurmont Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		24a. REC'D BY REGISTRAR DATE FEB 9 '59	
ADDRESS Thurmont, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

Reg. Dist. 15

PLACE OF DEATH	HOME
DECEASED	Frederick
DATE OF DEATH	11-1-1903
AGE	Thirteen
SEX	Male
CAUSE OF DEATH	Throat

NAME OF DECEASED	Elizabeth E. Flagg
DATE OF DEATH	Sept. 1, 1903
AGE	80
SEX	Female
CAUSE OF DEATH	White
PLACE OF DEATH	Home
DECEASED	David Wilson
DATE OF DEATH	Sept. 1, 1903
AGE	80
SEX	Female
CAUSE OF DEATH	White
PLACE OF DEATH	Home
DECEASED	Mrs. Thomas W. Lynn Thimont, Md.
DATE OF DEATH	Sept. 1, 1903
AGE	80
SEX	Female
CAUSE OF DEATH	White
PLACE OF DEATH	Home

NAME OF DECEASED	Y. Franklin Birney
DATE OF DEATH	Sept. 1, 1903
AGE	80
SEX	Male
CAUSE OF DEATH	White
PLACE OF DEATH	Home
DECEASED	United Western Cem. Thimont Maryland
DATE OF DEATH	Sept. 1, 1903
AGE	80
SEX	Female
CAUSE OF DEATH	White
PLACE OF DEATH	Home

NAME OF DECEASED	Ray or E. Cooper
DATE OF DEATH	Sept. 1, 1903
AGE	80
SEX	Male
CAUSE OF DEATH	White
PLACE OF DEATH	Home

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1858

CERTIFICATE OF DEATH

01872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 1/2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital		d. STREET ADDRESS 2400 Libert Heights Avenue	
3. NAME OF DECEASED (Type or print) First FRANKLIN Middle KREAMER Last GEISEY		4. DATE OF DEATH Month February Day 21, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Transfer Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Geisey		14. MOTHER'S MAIDEN NAME Amelia Stull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT 10 West Madison Street, Miss Flossie M. Geisey, Baltimore 1, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bedsores took turn		INTERVAL BETWEEN ONSET AND DEATH 570. 570.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 20, 1959 to Feb. 21, 1959 , that I last saw the deceased alive on Feb. 20, 1959 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. H. Kline		ADDRESS (Street, city or town, state) North Market Street DATE SIGNED 2/23/1959	
PHYSICIAN'S NAME (Type) Dr. H. F. Kline		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORY Utica Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 25 '59	
		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

0.125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1859

CERTIFICATE OF DEATH

Reg. Dist. No.

01873

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LIBERTY TOWN RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry J Glisan				4. DATE OF DEATH Month Day Year Feb 18 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 12 - 1888		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME CHARLES E GLISAN				14. MOTHER'S MAIDEN NAME MARY KELLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-36-0085			
17. INFORMANT HILDA GLISAN				Address MD MT AIRY R4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (Heart disease) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, bilateral							INTERVAL BETWEEN ONSET AND DEATH 12 hours 10 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/18 , 19 58 , to 2/18 , 19 59 , that I last saw the deceased alive on 2/18 , 19 59 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V Chase				ADDRESS (Street, city or town, state) 4 E. Church St			
DATE SIGNED 2/19/59							
PHYSICIAN'S NAME (Type) Henry V. Chase				Frederick Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/21/59		22c. NAME OF CEMETERY OR CREMATORY CENTRAL		22d. LOCATION (City, town, or county) (State) FREDERICK COUNTY MD	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. H. H. Jones				ADDRESS Libertytown, Md		24a. REC'D BY REGISTRAR FEB 24 59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hearn			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1860

CERTIFICATE OF DEATH

01874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28 Taney Apartments				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHESTER Middle FRANKLIN Last GOODMAN				4. DATE OF DEATH Month February Day 12 Year 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 July 1909		9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Garland Jewell				14. MOTHER'S MAIDEN NAME Ruth Goodman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ruth Kimmel (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple decubitus (c) Cerebral palsy (since childhood)						INTERVAL BETWEEN ONSET AND DEATH 1 Month 5 Months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/29 , 19 58 , to 2/12 , 19 59 , that I last saw the deceased alive on 2/10 , 19 59 , and that death occurred at 8 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick Shopping Center DATE SIGNED 14 Feb 1959							
ACTUAL SIGNATURE Ralph L. Michels				M.D. Frederick, Md.			
PHYSICIAN'S NAME (Type) Ralph L. Michels, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-16-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01875

1886

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#2				c. LENGTH OF STAY IN 1b 6 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION New Design Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUTH Middle VIRGINIA Last HANDLEY				4. DATE OF DEATH Month February Day 20 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 27, 1925	
9. AGE (In years last birthday) 33 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No			
16. SOCIAL SECURITY NO. 218-24-1421				17. INFORMANT Mr. Earl E. Handley-Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis, questionable DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-9-58 , to 2-20-58 , that I last saw the deceased alive on 2-17-59 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 2/20/1959							
ACTUAL SIGNATURE Dr. Rex R. Martin M.D.				PHYSICIAN'S NAME (Type) Dr. Rex R. Martin Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE FEB 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		123 Main St		Heart Disease		Jan 15, 1945		10:00 AM		City Hospital		J. Smith, M.D.		A. Jones, Registrar	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Last Medical Examination		Manner of Death		Burial or Disposition		Funeral Home		Burial Place		Date of Burial		Signature of Minister	
Teacher		Married		High School		Catholic		Hypertension		Jan 10, 1945		Natural		Buried		St. John's		St. John's Cemetery		Jan 18, 1945		P. Brown, Minister	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Burial Director		Signature of Undertaker		Signature of Cemetery		Signature of Funeral Home		Signature of Burial Place		Signature of Date of Burial		Signature of Minister	
John Doe		Jane Doe		J. Smith, M.D.		A. Jones, Registrar		P. Brown, Minister		St. John's		St. John's Cemetery		Jan 18, 1945		P. Brown, Minister		St. John's Cemetery		Jan 18, 1945		P. Brown, Minister	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural R. F. D. #6		c. LENGTH OF STAY IN 1b 40yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reichs Ford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELMER ELLSWORTH HILDEBRAND		4. DATE OF DEATH Month February Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason (Retired -Self Employed)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Hildebrand		14. MOTHER'S MAIDEN NAME Mary Jane Shafer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-14-5294	
17. INFORMANT R.F.D. # 6, Joseph Hildebrand; Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 10yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1959 to Feb. 7, 1959 , that I last saw the deceased alive on Feb. 6, 1959 , and that death occurred at 12:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 North Market St. Frederick, Md. DATE SIGNED 2/7/59			
ACTUAL SIGNATURE B. O. Thomas M.D.		22b. DATE THEREOF 2-9-59	
PHYSICIAN'S NAME (Type) B. O. Thomas, M.D.		22c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. LOCATION (City, town, or county) (State) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. RECEIVED BY REGISTRAR FEB 10 59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

2

NAME OF DECEASED

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JOSEPH J. JACOBSON		JANUARY 1, 1893		NEW YORK CITY	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
120 NORTH HANCOCK ST.		JANUARY 1, 1933		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		HEART DISEASE		NATURAL	
EDUCATION		SEX		RACE	
HIGH SCHOOL		MALE		WHITE	
RELIGION		TEMPERANCE		HABITS	
CATHOLIC		NONE		NONE	
PREVIOUS ILLNESS		TREATMENT		BURIAL	
NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1861

CERTIFICATE OF DEATH

Reg. Dist. No.

01877

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-21-1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Samuel T. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Emma ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT <u>Horace Johnson, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2/15</u> , 19 <u>59</u> , to <u>2/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/24</u> , 19 <u>59</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>2/25/59</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-28-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1862

Reg. Dist. No.

01878

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GAS HOUSE PIKE at LINGANORE Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FREDERICK RT # 1.	
3. NAME OF DECEASED (Type or print) RACHEL E. KEENEY		4. DATE OF DEATH Month FEBRUARY Day 14 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME WILLIAM R. BOTTOMLY		14. MOTHER'S MAIDEN NAME OCTAVIA Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-30-2951	
17. INFORMANT MRS. FRANK W. ABEL		Address KENSINGTON, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overance of Trauma 982x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stab wound of upper left lung DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Minute
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. THOMAS M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. THOMAS MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) FREDERICK Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey Jr.		24a. REC'D BY REGISTRAR DATE FEB 19 '59	
ADDRESS Frederick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

DEATH
CERTIFICATE

PROSECUTOR

ATTORNEY

REPORT

TESTIMONY

NAME OF DECEASED *John Doe* RESIDENCE *123 Main St. Baltimore, Md.*

DATE OF DEATH *Jan. 1, 1900* PLACE OF DEATH *At Home*

CAUSE OF DEATH *Heart Disease* NATURE OF DISEASE *Coronary Arteriosclerosis*

AGE *50* SEX *Male* OCCUPATION *Teacher*

EDUCATION *High School* RELIGION *Methodist*

DATE OF BIRTH *Dec. 15, 1849* PLACE OF BIRTH *Baltimore, Md.*

DATE OF DEATH *Jan. 1, 1900* PLACE OF DEATH *At Home*

John Doe
Teacher
123 Main St.
Baltimore, Md.

Heart Disease
Coronary Arteriosclerosis

50 *Male* *Teacher*

High School *Methodist*

Dec. 15, 1849 *Baltimore, Md.*

Jan. 1, 1900 *At Home*

John Doe *Teacher* *123 Main St.* *Baltimore, Md.*

Heart Disease *Coronary Arteriosclerosis*

50 *Male* *Teacher*

High School *Methodist*

Dec. 15, 1849 *Baltimore, Md.*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01879

1863

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) MINNIE SPRINGER KELLER		4. DATE OF DEATH Month February		Day 20,		Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1890	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher		10b. KIND OF BUSINESS OR INDUSTRY Grade School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Edward Keller		14. MOTHER'S MAIDEN NAME Valietta Weagley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT 3912 Virginia Avenue, Mrs. J. Ridgely Sheridan, Charleston, W.Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Bronchogenic Carcinoma, Rt. 162.1 DUE TO lung with bone, kidney and pulmonary metastases Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) lung with bone, kidney and pulmonary metastases								INTERVAL BETWEEN ONSET AND DEATH 1 year³	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Colon, operated 1951 - Cured.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)					
21. I certify that I attended the deceased from July , 19 58 to 20 Feb , 19 59 , that I last saw the deceased alive on 19 Feb , 19 59 , and that death occurred at 12:10 P M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Charles H. Conley, Jr.		M.D.		ADDRESS (Street, city or town, state) Professional Building		DATE SIGNED 2/20/1959			
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley		Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick,		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 24 59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01880

Reg. Dist. No.

1873

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VIRGINIA AVE. & POTOMAC STREET			d. STREET ADDRESS I Virginia Ave. & Potomas St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) George William Kimmel			4. DATE OF DEATH Feburary 27 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15 1895 63rs.		9. AGE (in years last birthday) 63rs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Engineer		10b. KIND OF BUSINESS OR INDUSTRY R.R. Engineer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Kimmell			14. MOTHER'S MAIDEN NAME Catherine Wagner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 176-01-6918		17. INFORMANT 2514 Garrett Avenue, Mrs. Lillian E. Kimmell, Baltimore 14, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute and Chronic Coronary Artery Occlusions (c) Healed Anterior + Posterior Myocardial Infarctions PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Healed Anterior + Posterior Myocardial Infarctions					INTERVAL BETWEEN ONSET AND DEATH Minute Yes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Feburary 28, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 2, 1959	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus

STATEMENT OF DEATH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>Jan 15 1925</i>		PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>123 Main St, New York City</i>		OCCUPATION <i>Teacher</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		RELIGION <i>Protestant</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		SYMPTOMS <i>Angina pectoris</i>		TREATMENT <i>Medical</i>		HISTORY <i>Long</i>		FAMILY HISTORY <i>None</i>	
SIGNATURE OF EXAMINER <i>Dr. J. Smith</i>		DATE <i>Jan 15 1925</i>		PLACE <i>New York City</i>		COUNTY <i>New York</i>		STATE <i>New York</i>		FEDERAL BUREAU OF INVESTIGATION <i>None</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1888

CERTIFICATE OF DEATH

Reg. Dist. No.

01881

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>WILLIAM</u> Middle <u>KINTZ</u> Last				4. DATE OF DEATH <u>FEB</u> Month <u>18</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery-Meat</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Jacob L. Kintz</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Rutzahn</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>			
16. SOCIAL SECURITY NO. <u>217-03-6052</u>				17. INFORMANT <u>Mr. Chas. Kintz, Walkersville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic and atherosclerotic disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>30 hours</u> <u>several days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 17, 1959</u> , to <u>Feb. 18, 1959</u> , that I last saw the deceased alive on <u>Feb. 18, 1959</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. Dettbarn</u> M.D.				ADDRESS (Street, city or town, state) <u>Walkersville</u> DATE SIGNED <u>Feb. 20/59</u>			
PHYSICIAN'S NAME (Type) <u>E. A. DETTBARN</u> Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>M. Liberty Town, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton, Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1864

CERTIFICATE OF DEATH

Reg. Dist. No.

01882

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN TB 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown			
				f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doris Middle C. Last Koogle				4. DATE OF DEATH Month 2 Day 22 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/8/1910	
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John Fink				14. MOTHER'S MAIDEN NAME Bessie Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-36-2518		17. INFORMANT Bruce Koogle, Jr., Middletown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO with Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Exploratory operation Dec 1958) INTERVAL BETWEEN ONSET AND DEATH 12 mo.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 1958, to Dec 22 , 1959, that I last saw the deceased alive on Dec 22 , 1959, and that death occurred at 1055 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Middletown Md DATE SIGNED Feb 24 59							
ACTUAL SIGNATURE J Elmer Harp M.D.				PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp Middletown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/25/1959		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE FEB 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1865

CERTIFICATE OF DEATH

Reg. Dist. No.

01883

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 17 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle KOONTZ Last KOONTZ		4. DATE OF DEATH Month February Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Feb 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11. BIRTHPLACE (State or foreign country) Frederick, Maryland	
13. FATHER'S NAME Vernon M. Koontz		14. MOTHER'S MAIDEN NAME Dorothy M. Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Vernon M. Koontz (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis foetalis 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 17 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 8 , 19 59 , to Feb 8 , 19 59 , that I last saw the deceased alive on Feb 8 , 19 59 , and that death occurred at 9:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St., DATE SIGNED 10 Feb 1959			
ACTUAL SIGNATURE Bernard O. Thomas, Jr. M.D.		PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D. Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-10-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REGD BY REGISTRAR FEB 11 1959	
24b. REGISTRAR'S SIGNATURE <i>Charles A. Thomas</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069343XV7

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01884

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#5		c. LENGTH OF STAY IN 1b 11 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#5			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Braddock Heights				d. STREET ADDRESS Near Braddock Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last LAMM				4. DATE OF DEATH Month February Day 2 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1877		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Stockman				14. MOTHER'S MAIDEN NAME Lydia Keller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Mabel E. Mills, Lovettsville, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 422.1 DUE TO CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 12 Hours 5Years-Plus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/3/1959	
EXAMINER'S NAME (Type) Dr. B. O. Thomas				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran Cem.		22d. LOCATION (City, town, or county) (State) Jefferson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR FEB 4 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1882

Name of Deceased		Age		Sex		Color		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Medical Examiner		Signature of Coroner	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1866

CERTIFICATE OF DEATH

Reg. Dist. No.

01885

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 267 West Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA		First EUGENIA		Last LEASE		4. DATE OF DEATH Month February Day 14, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1871		9. AGE (In years last birthday) yrs. 88	10. IF UNDER 1 YEAR Months 3 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Lease				14. MOTHER'S MAIDEN NAME Mary Houck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-7799		17. INFORMANT 107 East Church Street, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO (c) Arterio vascular disease						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 5 days +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan 1942 , to Feb 14, 1959 , that I last saw the deceased alive on Feb 14, 1959 , and that death occurred at 11:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. O. Thomas		M.D. Professional Building		ADDRESS (Street, city or town, state)		DATE SIGNED 2/16/59	
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 17, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. CITY		8. COUNTY		9. STATE		10. ZIP CODE	
11. OCCUPATION		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. PLACE OF INTERMENT		15. DATE OF INTERMENT	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1874

CERTIFICATE OF DEATH

Reg. Dist. No.

01886

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick				c. LENGTH OF STAY IN 1b 64 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 West "B"				d. STREET ADDRESS 209 West "B"			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Leslie Cleveland Moler				4. DATE OF DEATH Month Day Year 2 11 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-19-1892	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman				10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Moler				14. MOTHER'S MAIDEN NAME Ella Chestnut			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes World 1				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Rebecca A. Moler, Brunswick, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1960 DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While o. m. Not while o. m. <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/7 19 59 to 3/11 19 59 , that I last saw the deceased alive on 2/10 19 59 , and that death occurred at 11 M, from the causes and on the date stated above. ADDRESS (Street, City or town, State) Brunswick, Md DATE SIGNED 3/11/59							
ACTUAL SIGNATURE [Signature] M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-14-1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Feste ADDRESS Brunswick, Maryland				24a. REC'D BY REGISTRAR FEB 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

1934

Age 70

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 70		DATE OF DEATH 10-15-34	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
OCCUPATION Retired		EDUCATION High School		RELIGION Methodist		MARRIAGE Married	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFIED BY J. H. Harris		DATE 10-15-34	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		J. H. Harris		J. H. Harris		J. H. Harris	
DATE		DATE		DATE		DATE	
10-15-34		10-15-34		10-15-34		10-15-34	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01887

1890

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>		c. LENGTH OF STAY IN 1b <i>49</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GEORGE FERDINAND MYERS</i>		4. DATE OF DEATH Month <i>FEB</i> Day <i>19</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 3 1890</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Switch tender</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George Edward Myers</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Stewart</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Mary E. Myers, Walkersville, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> <i>162.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic malignancy</i> (c) <i>Primary bronchogenic carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>8 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>July</i> , 1957, to <i>February</i> , 1959, that I last saw the deceased alive on <i>Feb. 18</i> , 1959, and that death occurred at <i>3:30 A.M.</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>E. A. Dettbarn</i> M.D.		ADDRESS (Street, city or town, state) <i>Walkersville, Md.</i> DATE SIGNED <i>Feb. 20/59</i>	
PHYSICIAN'S NAME (Type) <i>E. A. DETTBARN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/22/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Y. C. Barton</i> ADDRESS <i>Walkersville, Md.</i>		24a. REC'D BY REGISTRAR <i>FEB 24 '59</i> DATE	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1867

CERTIFICATE OF DEATH

Reg. Dist. No.

1888

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 400 Carroll Parkway	
3. NAME OF DECEASED (Type or print) HARRIET HOFFMAN NICODEMUS		4. DATE OF DEATH Month February Day 5 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Jan 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Griffin Hoffman		14. MOTHER'S MAIDEN NAME Harriet Hutchinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. L. M. Freeze		Address (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 days Yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma; Chr. Rheumatic Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1958 , to Feb 5, 1959 , that I last saw the deceased alive on Feb 5, 1959 , and that death occurred at 10:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Stone		ADDRESS (Street, city or town, state) 415 3rd St Frederick 2-5-59	
PHYSICIAN'S NAME (Type) Thomas E. Stone		DATE SIGNED 2-5-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-8-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. JONES</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1890</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1945</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Date of admission to hospital: <u>1945</u></p>	
<p>11. Name of attending physician: <u>Dr. J. J. Jones</u></p>		<p>12. Name of hospital: <u>St. Mary's Hospital</u></p>	
<p>13. Name of funeral home: <u>John J. Jones</u></p>		<p>14. Name of cemetery: <u>St. Mary's Cemetery</u></p>	
<p>15. Name of informant: <u>John J. Jones</u></p>		<p>16. Name of informant: <u>John J. Jones</u></p>	
<p>17. Name of informant: <u>John J. Jones</u></p>		<p>18. Name of informant: <u>John J. Jones</u></p>	
<p>19. Name of informant: <u>John J. Jones</u></p>		<p>20. Name of informant: <u>John J. Jones</u></p>	
<p>21. Name of informant: <u>John J. Jones</u></p>		<p>22. Name of informant: <u>John J. Jones</u></p>	
<p>23. Name of informant: <u>John J. Jones</u></p>		<p>24. Name of informant: <u>John J. Jones</u></p>	
<p>25. Name of informant: <u>John J. Jones</u></p>		<p>26. Name of informant: <u>John J. Jones</u></p>	
<p>27. Name of informant: <u>John J. Jones</u></p>		<p>28. Name of informant: <u>John J. Jones</u></p>	
<p>29. Name of informant: <u>John J. Jones</u></p>		<p>30. Name of informant: <u>John J. Jones</u></p>	
<p>31. Name of informant: <u>John J. Jones</u></p>		<p>32. Name of informant: <u>John J. Jones</u></p>	
<p>33. Name of informant: <u>John J. Jones</u></p>		<p>34. Name of informant: <u>John J. Jones</u></p>	
<p>35. Name of informant: <u>John J. Jones</u></p>		<p>36. Name of informant: <u>John J. Jones</u></p>	
<p>37. Name of informant: <u>John J. Jones</u></p>		<p>38. Name of informant: <u>John J. Jones</u></p>	
<p>39. Name of informant: <u>John J. Jones</u></p>		<p>40. Name of informant: <u>John J. Jones</u></p>	
<p>41. Name of informant: <u>John J. Jones</u></p>		<p>42. Name of informant: <u>John J. Jones</u></p>	
<p>43. Name of informant: <u>John J. Jones</u></p>		<p>44. Name of informant: <u>John J. Jones</u></p>	
<p>45. Name of informant: <u>John J. Jones</u></p>		<p>46. Name of informant: <u>John J. Jones</u></p>	
<p>47. Name of informant: <u>John J. Jones</u></p>		<p>48. Name of informant: <u>John J. Jones</u></p>	
<p>49. Name of informant: <u>John J. Jones</u></p>		<p>50. Name of informant: <u>John J. Jones</u></p>	
<p>51. Name of informant: <u>John J. Jones</u></p>		<p>52. Name of informant: <u>John J. Jones</u></p>	
<p>53. Name of informant: <u>John J. Jones</u></p>		<p>54. Name of informant: <u>John J. Jones</u></p>	
<p>55. Name of informant: <u>John J. Jones</u></p>		<p>56. Name of informant: <u>John J. Jones</u></p>	
<p>57. Name of informant: <u>John J. Jones</u></p>		<p>58. Name of informant: <u>John J. Jones</u></p>	
<p>59. Name of informant: <u>John J. Jones</u></p>		<p>60. Name of informant: <u>John J. Jones</u></p>	
<p>61. Name of informant: <u>John J. Jones</u></p>		<p>62. Name of informant: <u>John J. Jones</u></p>	
<p>63. Name of informant: <u>John J. Jones</u></p>		<p>64. Name of informant: <u>John J. Jones</u></p>	
<p>65. Name of informant: <u>John J. Jones</u></p>		<p>66. Name of informant: <u>John J. Jones</u></p>	
<p>67. Name of informant: <u>John J. Jones</u></p>		<p>68. Name of informant: <u>John J. Jones</u></p>	
<p>69. Name of informant: <u>John J. Jones</u></p>		<p>70. Name of informant: <u>John J. Jones</u></p>	
<p>71. Name of informant: <u>John J. Jones</u></p>		<p>72. Name of informant: <u>John J. Jones</u></p>	
<p>73. Name of informant: <u>John J. Jones</u></p>		<p>74. Name of informant: <u>John J. Jones</u></p>	
<p>75. Name of informant: <u>John J. Jones</u></p>		<p>76. Name of informant: <u>John J. Jones</u></p>	
<p>77. Name of informant: <u>John J. Jones</u></p>		<p>78. Name of informant: <u>John J. Jones</u></p>	
<p>79. Name of informant: <u>John J. Jones</u></p>		<p>80. Name of informant: <u>John J. Jones</u></p>	
<p>81. Name of informant: <u>John J. Jones</u></p>		<p>82. Name of informant: <u>John J. Jones</u></p>	
<p>83. Name of informant: <u>John J. Jones</u></p>		<p>84. Name of informant: <u>John J. Jones</u></p>	
<p>85. Name of informant: <u>John J. Jones</u></p>		<p>86. Name of informant: <u>John J. Jones</u></p>	
<p>87. Name of informant: <u>John J. Jones</u></p>		<p>88. Name of informant: <u>John J. Jones</u></p>	
<p>89. Name of informant: <u>John J. Jones</u></p>		<p>90. Name of informant: <u>John J. Jones</u></p>	
<p>91. Name of informant: <u>John J. Jones</u></p>		<p>92. Name of informant: <u>John J. Jones</u></p>	
<p>93. Name of informant: <u>John J. Jones</u></p>		<p>94. Name of informant: <u>John J. Jones</u></p>	
<p>95. Name of informant: <u>John J. Jones</u></p>		<p>96. Name of informant: <u>John J. Jones</u></p>	
<p>97. Name of informant: <u>John J. Jones</u></p>		<p>98. Name of informant: <u>John J. Jones</u></p>	
<p>99. Name of informant: <u>John J. Jones</u></p>		<p>100. Name of informant: <u>John J. Jones</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1891

CERTIFICATE OF DEATH

01889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN TB Since 1-5-56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home		e. STREET ADDRESS 909 North Market Street	
3. NAME OF DECEASED (Type or print) First MARTHA Middle V. Last NUSBAUM		4. DATE OF DEATH Month February Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Nov 1868
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel A. Nusbaum	
14. MOTHER'S MAIDEN NAME Hettie Snyder		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Belle Fleetwood, Jackson, N. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute auricular fibrillation 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 7 hours
21. I certify that I attended the deceased from Jan 5 , 19 56 , to Feb 10 , 19 59 , that I last saw the deceased alive on Feb 10 , 19 59 , and that death occurred at 8:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 17 E. Second St., 11 Feb 1959			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE H. L. Fahrney		M.D. 17 E. Second St.,	
PHYSICIAN'S NAME (Type) H. L. Fahrney, M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-13-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Md.		24a. REC'D BY REGISTRAR DATE FEB 16 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECEASED

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1981
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. DATE OF DEATH 4/4/68	
3. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION WASHINGTON, D.C.		4. CAUSE OF DEATH HEART DISEASE	
5. MANNER OF DEATH NATURAL		6. SEX MALE	
7. AGE 35		8. RACE WHITE	
9. BIRTH DATE 1/24/33		10. BIRTH PLACE MOBILE, ALABAMA	
11. MARITAL STATUS MARRIED		12. OCCUPATION ATTORNEY	
13. SIGNATURE OF DECEASED JAMES EARL RAY		14. SIGNATURE OF WITNESS JAMES EARL RAY	
15. SIGNATURE OF PHYSICIAN JAMES EARL RAY		16. SIGNATURE OF CORONER JAMES EARL RAY	
17. SIGNATURE OF DEATH REGISTRAR JAMES EARL RAY		18. SIGNATURE OF CLERK JAMES EARL RAY	
19. SIGNATURE OF JUDGE JAMES EARL RAY		20. SIGNATURE OF SHERIFF JAMES EARL RAY	
21. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		22. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
23. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		24. SIGNATURE OF VOTING CLERK JAMES EARL RAY	
25. SIGNATURE OF POLL CLERK JAMES EARL RAY		26. SIGNATURE OF BALLOT CLERK JAMES EARL RAY	
27. SIGNATURE OF BALLOT BOX CLERK JAMES EARL RAY		28. SIGNATURE OF BALLOT COUNT CLERK JAMES EARL RAY	
29. SIGNATURE OF BALLOT TALLY CLERK JAMES EARL RAY		30. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
31. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		32. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
33. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		34. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
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41. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		42. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
43. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		44. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
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49. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		50. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
51. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		52. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
53. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		54. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
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71. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		72. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
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75. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		76. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
77. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		78. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
79. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		80. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
81. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		82. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
83. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		84. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
85. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		86. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
87. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		88. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
89. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		90. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
91. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		92. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
93. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		94. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
95. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		96. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
97. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		98. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	
99. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY		100. SIGNATURE OF BALLOT TOTAL CLERK JAMES EARL RAY	

01890

CERTIFICATE OF DEATH

Reg. Dist. No.

01890

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (If deceased lived. If institution; Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 35 Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 East "B"		d. STREET ADDRESS 8 East "B"		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Edgar Painter		First Middle Last		4. DATE OF DEATH Month 2 Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-18-1871		9. AGE (In years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. Co		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Robert Painter		14. MOTHER'S MAIDEN NAME Jane ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. James Painter		17. INFORMANT Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 7/16		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Brunswick, Maryland	
20f. (City or town) Brunswick		(County) Frederick		(State) Maryland	
21. I certify that I attended the deceased from Jan 26 1959 to 2/2 1959 , that I last saw the deceased alive on Jan 26 1959 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 2/4/59					
ACTUAL SIGNATURE J. G. F. Smith		M.D. Brunswick, Maryland			
PHYSICIAN'S NAME (Type) J. G. F. Smith		Brunswick Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-1959		22c. NAME OF CEMETERY OR CREMATORY Edge Hill	
22d. LOCATION (City, town, or county) Charlestown, West Virginia		(State) West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Fete & Son		ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE FEB 5 1959	
24b. REGISTRAR'S SIGNATURE John C. Fete					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

CERTIFICATE OF DEATH

Age 20-24

875

MADE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DEATH OF PERSON

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CLERK

12. SIGNATURE OF JUDGE

13. SIGNATURE OF SHERIFF

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF COURT

17. SIGNATURE OF STATE

18. SIGNATURE OF COUNTY

19. SIGNATURE OF CITY

20. SIGNATURE OF TOWNSHIP

21. SIGNATURE OF PARISH

22. SIGNATURE OF VILLAGE

23. SIGNATURE OF HAMLET

24. SIGNATURE OF CENSUS TRACT

DEPARTMENT OF HEALTH

THIS IS THE OFFICIAL RECORD OF THE DEATH OF THE ABOVE NAMED PERSON, AND IT IS HEREBY CERTIFIED THAT THE SAME IS TRUE AND CORRECT.

TO ANYONE

FOR THE PURPOSE OF OBTAINING A COPY

1892

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R#5</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Myersville</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs 1 mo 13 d</u>				d. STREET ADDRESS <u>Frederick County Chronic Hosp</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick County Chronic Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Upton</u> Middle <u>Walter</u> Last <u>Palmer</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 15, 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Hezekiah Palmer</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Stattlemyer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Ruth Crawford R.R. Supt. Frederick County Chronic Hosp</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> (c) <u>Branchial Asthma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>3 yrs.</u> <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>11/30</u> , 19 <u>56</u> , to <u>2/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>59</u> , and that death occurred at <u>5 a.m.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>H. Kline</u>				M.D. <u>J. N. Markert</u> <u>Frederick Co. Feb 16 59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. H. Kline</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/17/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Myersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 18 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1885</u></p>		<p>4. Age: <u>48</u></p>	
<p>5. Place of birth: <u>St. Louis, Mo.</u></p>		<p>6. Date of death: <u>Dec 10, 1933</u></p>	
<p>7. Cause of death: <u>Myocardial infarction</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>Dec 15, 1933</u></p>		<p>12. Office of registration: <u>Baltimore</u></p>	

This certificate is required by law to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. It is the duty of the physician or other person having knowledge of the cause of death to fill out this certificate and to sign it. The certificate is a legal document and its contents are subject to the laws of the State of Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1893

CERTIFICATE OF DEATH

Reg. Dist. No.

01892

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown-Rural		c. LENGTH OF STAY IN 1b Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) Valley View Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIE Middle BIRELY Last PARKER		4. DATE OF DEATH Month February Day 7 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Feb 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hostess		10b. KIND OF BUSINESS OR INDUSTRY College	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. W. Birely		14. MOTHER'S MAIDEN NAME Martha E. Feezer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. Martha K. Slemmer		225 W. Second St., Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of bladder.			INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 5 , 19 58 , to Feb. 7 , 19 59 , that I last saw the deceased alive on Feb. 6 , 19 59 , and that death occurred at 7:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard O. Thomas, Jr. M.D.		ADDRESS (Street, city or town, state) 228 N. Market St., DATE SIGNED 9 Feb 1959	
PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-59	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR Feb 10 1959		24b. REGISTRAR'S SIGNATURE Arthur P. H.	

CERTIFICATE OF DEATH

1903

Page One of Two

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1858		Boston, Mass.		Boston, Mass.		Heart Disease		Jan 15, 1903		10:00 AM		Home		J. A. Smith		W. B. Jones	
Occupation		Married		Single		Widowed		Divorced		Color		Race		Religion		Education		Profession		Trade		Industry	
Farmer		Yes		No		No		No		White		Caucasian		Protestant		High School		None		None		None	
Place of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Home		Heart Disease		Jan 15, 1903		10:00 AM		Home		J. A. Smith		W. B. Jones		Jan 15, 1903		10:00 AM		Home		J. A. Smith		W. B. Jones	
Place of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Home		Heart Disease		Jan 15, 1903		10:00 AM		Home		J. A. Smith		W. B. Jones		Jan 15, 1903		10:00 AM		Home		J. A. Smith		W. B. Jones	

1894

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle Ambrose Last Sanders		4. DATE OF DEATH Month February Day 25 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1910
9. AGE (In years last birthday) yrs. 48		10. IF UNDER 1 YEAR Months Days Hours Min. 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equip. Operator Quarry+Contractor		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Preston Sanders		14. MOTHER'S MAIDEN NAME Bertie Gillen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-1071	
17. INFORMANT Mrs. Hilda Sanders		Address Sabillasville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) myocardial infarction, old DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2-3 mos.			INTERVAL BETWEEN ONSET AND DEATH. 15-30 MIN.
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 March 59 to 25 Feb 1959 , that I last saw the deceased alive on 21 February 1959 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Harry H. Young M.D. ADDRESS (Street, city or town, state) Blue Ridge Summit Pa DATE SIGNED 2-26-59 PHYSICIAN'S NAME (Type) Harry H. Young			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-59	
22c. NAME OF CEMETERY OR CREMATORY Bethel Church of God		22d. LOCATION (City, town, or county) (State) Cascade, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

Subj: William J. Sullivan
18 yrs. 10 mos.

Own home

Local address: 1010 N. 10th St.

Male

Heavy work. Operator. U.S.A.

Excessed. 1010 N. 10th St.

1010-01-1010

1010-01-1010

1010-01-1010

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1895

CERTIFICATE OF DEATH

Reg. Dist. No.

01894

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 32 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ada Middle Catherine Last Sauble		4. DATE OF DEATH Month February Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1885
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Smith		14. MOTHER'S MAIDEN NAME Anna Rush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-05-7304	
INFORMANT Ralph A. Sauble		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 20 min. 20 min.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 20 , 19 59 , to Feb. 20 , 19 59 that I last saw the deceased alive on Feb. 20 , 19 59 , and that death occurred at 5:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont - Md. DATE SIGNED 2/20/59 ACTUAL SIGNATURE James K. Gray M.D. T. Thurmont PHYSICIAN'S NAME (Type) James K. Gray			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-59	
22c. NAME OF CEMETERY OR CREMATORY Rocky Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Rocky Ridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager Thurmont, Maryland		24a. REC'D BY REGISTRAR FEB 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass			

Frederick

Maryland

Frederick

Thurmont

25 yrs.

Thurmont

Water Street

Own home

February 20

Adm. Catharine Sample

Mar. 3, 1932

White

Female

U.S.A.

Maryland

Own home

Honolulu

Anna Bush

George Smith

Thurmont, Md.

217-02-730

No.

James H. Gray

Rocky Ridge, Maryland

Rocky Ridge Cemetery

2-22-30

Female

Thurmont, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,8,9,11,12. See: Birth Cert. et

1868

CERTIFICATE OF DEATH

01895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Fredrick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredrick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FREDERICK MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>335 S-Monroe St</u>			
3. NAME OF DECEASED (Type or print) First <u>Dianna</u> Middle <u>Lynn</u> Last <u>Stevins</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 8, 1959</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Carl Stevins</u>				14. MOTHER'S MAIDEN NAME <u>Margie Louise Gregory</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		Address <u>Balto, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Nephritic Mesothelioma Disease</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Respiratory failure</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-8</u> , 19 <u>59</u> , to <u>2-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-9</u> , 19 <u>59</u> , and that death occurred at <u>10 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Fred J. Heldrich</u> M.D. <u>220 N. Market St</u> PHYSICIAN'S NAME (Type) <u>FRED J. HELDRICH</u> <u>Frederick</u> <u>Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10 Feb 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Hutchinson & Son, Frederick, Md</u>				24a. REC'D BY REGISTRAR <u>FEB 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

2269204 XV23

CERTIFICATE OF DEATH

1808

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1863</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1885</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. DATE OF DEATH <i>Jan 15 1908</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF CLERK <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>	
21. SIGNATURE OF JURY <i>John Doe</i>		22. SIGNATURE OF JURY <i>John Doe</i>	
23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>	
27. SIGNATURE OF JURY <i>John Doe</i>		28. SIGNATURE OF JURY <i>John Doe</i>	
29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>	
33. SIGNATURE OF JURY <i>John Doe</i>		34. SIGNATURE OF JURY <i>John Doe</i>	
35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>	
39. SIGNATURE OF JURY <i>John Doe</i>		40. SIGNATURE OF JURY <i>John Doe</i>	
41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>	
45. SIGNATURE OF JURY <i>John Doe</i>		46. SIGNATURE OF JURY <i>John Doe</i>	
47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>	
51. SIGNATURE OF JURY <i>John Doe</i>		52. SIGNATURE OF JURY <i>John Doe</i>	
53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>	
57. SIGNATURE OF JURY <i>John Doe</i>		58. SIGNATURE OF JURY <i>John Doe</i>	
59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>	
63. SIGNATURE OF JURY <i>John Doe</i>		64. SIGNATURE OF JURY <i>John Doe</i>	
65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>	
69. SIGNATURE OF JURY <i>John Doe</i>		70. SIGNATURE OF JURY <i>John Doe</i>	
71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>	
75. SIGNATURE OF JURY <i>John Doe</i>		76. SIGNATURE OF JURY <i>John Doe</i>	
77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>	
81. SIGNATURE OF JURY <i>John Doe</i>		82. SIGNATURE OF JURY <i>John Doe</i>	
83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>	
87. SIGNATURE OF JURY <i>John Doe</i>		88. SIGNATURE OF JURY <i>John Doe</i>	
89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>	
93. SIGNATURE OF JURY <i>John Doe</i>		94. SIGNATURE OF JURY <i>John Doe</i>	
95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>	
99. SIGNATURE OF JURY <i>John Doe</i>		100. SIGNATURE OF JURY <i>John Doe</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1869

CERTIFICATE OF DEATH

01896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY in 1b <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Adams town</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK WAYNE STINE</u>				4. DATE OF DEATH Month Day Year <u>Feb. 14 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 26 1958</u>	9. AGE (In years lost birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>1 13</u>	IF UNDER 24 HRS. Hours Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Earl E. Stine</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Himer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Earl E. Stine, Jr. Adams town, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dicros Bay, due to Paracolon</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>R. L. GUEST</u> M.D.				DATE SIGNED <u>7 E. Church St</u>			
PHYSICIAN'S NAME (Type) <u>R. L. GUEST</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louise Lane Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Unionville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. E. Barton</u>				ADDRESS <u>Whekersville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10 59</u>	
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

100039 V XV3

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1896
CERTIFICATE OF DEATH

01897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b Since 11-8-58	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle JANE Last STONEBURNER		4. DATE OF DEATH Month February Day 12 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 30, 1879
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Stoneburner		14. MOTHER'S MAIDEN NAME Sarah Ellen Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles A. Walters, Same as item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 10 hrs year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to Feb 12 , 19 59 , that I last saw the deceased alive on Feb 11 , 19 59 , and that death occurred at 12:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 E. Second St., DATE SIGNED 12 Feb 1959			
ACTUAL SIGNATURE H. L. Fahrney		M.D. Frederick, Md.	
PHYSICIAN'S NAME (Type) H. L. Fahrney, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		24. REG'D. BY REGISTRAR FEB 16 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01898

Reg. Dist. No.

1870

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6		d. STREET ADDRESS Quinn Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSHUA Middle HENRY Last SUMMERS		4. DATE OF DEATH Month February Day 11 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Aug 1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Philip W. Summers	
14. MOTHER'S MAIDEN NAME Margaret A. M. Zimmerman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-34-9329		17. INFORMANT Mrs. Howard U. Quinn (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Large intestine obstruction, cause deferred 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pending autopsy report - (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 59 , to 2-10 , 19 59 , that I last saw the deceased alive on 2-9 , 19 59 , and that death occurred at 7:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church St., DATE SIGNED 12 Feb 1959 ACTUAL SIGNATURE Rex R. Martin M.D. Frederick, Md. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-14-59	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		24a. REC'D BY REGISTRAR DATE FEB 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House			

CERTIFICATE OF DEATH

1270

NAME OF DECEASED		SEX		AGE	
JAMES H. HARRIS		Male		45	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
1234 Main St., Baltimore, Md.		Jan 15, 1950		Home	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
Myocardial Infarction		Natural		None	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE		FUNDAMENTAL CAUSE	
Coronary Thrombosis		Atherosclerosis		Hypertension	
CHIEF COMPLAINT		HISTORY OF PRESENT ILLNESS		PREVIOUS ILLNESSES	
Chest pain		Onset 12/20/49		Hypertension	
MEDICAL HISTORY		SURGICAL HISTORY		FAMILY HISTORY	
None		None		None	
TREATMENT		POST-MORTEM EXAMINATION		LABORATORY EXAMINATIONS	
None		None		None	
SIGNATURE OF PHYSICIAN		DATE		PLACE	
J. H. Harris		Jan 15, 1950		Baltimore, Md.	

NAME OF DECEASED		SEX		AGE	
JAMES H. HARRIS		Male		45	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
1234 Main St., Baltimore, Md.		Jan 15, 1950		Home	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
Myocardial Infarction		Natural		None	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE		FUNDAMENTAL CAUSE	
Coronary Thrombosis		Atherosclerosis		Hypertension	
CHIEF COMPLAINT		HISTORY OF PRESENT ILLNESS		PREVIOUS ILLNESSES	
Chest pain		Onset 12/20/49		Hypertension	
MEDICAL HISTORY		SURGICAL HISTORY		FAMILY HISTORY	
None		None		None	
TREATMENT		POST-MORTEM EXAMINATION		LABORATORY EXAMINATIONS	
None		None		None	
SIGNATURE OF PHYSICIAN		DATE		PLACE	
J. H. Harris		Jan 15, 1950		Baltimore, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01899

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#5				c. LENGTH OF STAY IN 1b Min.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clifton Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DeHAVEN Middle SAMUEL Last TOMS, SR.				4. DATE OF DEATH Month February Day 28 , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 5, 1901		9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Houseing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Toms				14. MOTHER'S MAIDEN NAME Mary Kauffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-9353		17. INFORMANT Address Mrs. Arthur L. Crum, Walkersville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 DAYS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/28/59	
EXAMINER'S NAME (Type) B. O. Thomas, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Utica Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Crum	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Department of Health, Baltimore, Maryland. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-CARDOLOGICAL
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Item 18 Film 299 3-10-59 and
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1898

01651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmittsburg, R.F.D. 2		c. LENGTH OF STAY IN life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmittsburg R.F.D. 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Christopher Eugene Topper			4. DATE OF DEATH Feb. 9 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1958		9. AGE (In years last birthday) yrs. 2 Months 14 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co.	
13. FATHER'S NAME Richard Curtis Topper			14. MOTHER'S MAIDEN NAME Hazel Eva Glaken		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Richard Topper, Emmittsburg, R.D. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Cardiac Failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Interstitial Broncho pneumonia probably Viral DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/9/59	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/11/1959		22c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CATHOLIC	
				22d. LOCATION (City, town, or county) (State) EMMITTSBURG, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence E. Wilson, Emmittsburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

2 V 89 V V V X V V

FOR STATE
HEALTH DEPT.

392

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1899

CERTIFICATE OF DEATH

01900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D.# 1 Fairfield, Pa.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Cornelius</u> Last <u>Tressler</u>				4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1868</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Adams Co. Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Tressler</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Kint</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>David Tressler, Fairfield, R.D.#1, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <u>advanced age.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct. 1, 1958</u> to <u>Feb 10, 1959</u> , that I last saw the deceased alive on <u>Feb. 9, 1959</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joe M. Henderson</u> M.D.				ADDRESS (Street, city or town, state) <u>Fairfield, Adams Co. Pa.</u> DATE SIGNED <u>2-10-59</u>			
PHYSICIAN'S NAME (Type) <u>IRA M. HENDERSON</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>2/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Jacob's</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfield, R.D.#1 Pa.</u>		24a. REC'D BY REGISTRAR <u>B 13 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Wilson</u>				ADDRESS <u>Fairfield, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Hume</u>	

C. E. Wilson

CERTIFICATE OF DEATH

1968

1. NAME OF DECEASED <u>JOHN J. BROWN</u>		2. SEX <u>MALE</u>		3. AGE <u>68</u>	
4. DATE OF DEATH <u>JUN 15 1968</u>		5. TIME OF DEATH <u>10:15 AM</u>		6. PLACE OF DEATH <u>HOME</u>	
7. CAUSE OF DEATH <u>HEART DISEASE</u>		8. MANNER OF DEATH <u>NATURAL</u>		9. PLACE OF BIRTH <u>NEW YORK</u>	
10. OCCUPATION <u>RETIRED</u>		11. MARITAL STATUS <u>MARRIED</u>		12. EDUCATION <u>HIGH SCHOOL</u>	
13. PREVIOUS ILLNESS <u>HYPERTENSION</u>		14. PRESENT ILLNESS <u>HEART DISEASE</u>		15. MEDICAL HISTORY <u>HEART DISEASE</u>	
16. PHYSICIAN'S SIGNATURE <u>DR. J. J. BROWN</u>		17. HOSPITAL SIGNATURE <u>DR. J. J. BROWN</u>		18. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
19. STATE SIGNATURE <u>DR. J. J. BROWN</u>		20. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		21. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
22. STATE SIGNATURE <u>DR. J. J. BROWN</u>		23. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		24. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
25. STATE SIGNATURE <u>DR. J. J. BROWN</u>		26. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		27. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
28. STATE SIGNATURE <u>DR. J. J. BROWN</u>		29. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		30. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
31. STATE SIGNATURE <u>DR. J. J. BROWN</u>		32. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		33. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
34. STATE SIGNATURE <u>DR. J. J. BROWN</u>		35. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		36. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
37. STATE SIGNATURE <u>DR. J. J. BROWN</u>		38. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		39. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
40. STATE SIGNATURE <u>DR. J. J. BROWN</u>		41. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		42. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
43. STATE SIGNATURE <u>DR. J. J. BROWN</u>		44. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		45. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
46. STATE SIGNATURE <u>DR. J. J. BROWN</u>		47. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		48. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
49. STATE SIGNATURE <u>DR. J. J. BROWN</u>		50. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		51. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
52. STATE SIGNATURE <u>DR. J. J. BROWN</u>		53. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		54. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
55. STATE SIGNATURE <u>DR. J. J. BROWN</u>		56. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		57. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
58. STATE SIGNATURE <u>DR. J. J. BROWN</u>		59. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		60. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
61. STATE SIGNATURE <u>DR. J. J. BROWN</u>		62. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		63. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
64. STATE SIGNATURE <u>DR. J. J. BROWN</u>		65. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		66. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
67. STATE SIGNATURE <u>DR. J. J. BROWN</u>		68. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		69. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
70. STATE SIGNATURE <u>DR. J. J. BROWN</u>		71. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		72. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
73. STATE SIGNATURE <u>DR. J. J. BROWN</u>		74. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		75. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
76. STATE SIGNATURE <u>DR. J. J. BROWN</u>		77. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		78. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
79. STATE SIGNATURE <u>DR. J. J. BROWN</u>		80. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		81. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
82. STATE SIGNATURE <u>DR. J. J. BROWN</u>		83. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		84. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
85. STATE SIGNATURE <u>DR. J. J. BROWN</u>		86. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		87. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
88. STATE SIGNATURE <u>DR. J. J. BROWN</u>		89. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		90. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
89. STATE SIGNATURE <u>DR. J. J. BROWN</u>		90. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		91. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
90. STATE SIGNATURE <u>DR. J. J. BROWN</u>		91. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		92. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
91. STATE SIGNATURE <u>DR. J. J. BROWN</u>		92. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		93. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
92. STATE SIGNATURE <u>DR. J. J. BROWN</u>		93. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		94. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
93. STATE SIGNATURE <u>DR. J. J. BROWN</u>		94. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		95. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
94. STATE SIGNATURE <u>DR. J. J. BROWN</u>		95. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		96. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
95. STATE SIGNATURE <u>DR. J. J. BROWN</u>		96. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		97. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
96. STATE SIGNATURE <u>DR. J. J. BROWN</u>		97. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		98. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
97. STATE SIGNATURE <u>DR. J. J. BROWN</u>		98. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		99. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	
98. STATE SIGNATURE <u>DR. J. J. BROWN</u>		99. FEDERAL SIGNATURE <u>DR. J. J. BROWN</u>		100. COUNTY SIGNATURE <u>DR. J. J. BROWN</u>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - JUNE 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1900

CERTIFICATE OF DEATH

01901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Frederick-Rural RD#7				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7				d. STREET ADDRESS Yellow Springs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Yellow Springs				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle EDWARD Last TWENTY				4. DATE OF DEATH Month February Day 26 , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Jan 1907	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager		10b. KIND OF BUSINESS OR INDUSTRY News-Post		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George L. Twentey				14. MOTHER'S MAIDEN NAME Sadie E. Summers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-3113		17. INFORMANT Address Mrs. Vada W. Twentey (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Biliary Cirrhosis 585x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Cholangiolytic Hepatitis DUE TO (c) 2 1/2 years						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug 1 , 1936, to Feb 26 , 1959, that I last saw the deceased alive on Feb 26 , 1959, and that death occurred at 3 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Stone M.D.				ADDRESS (Street, city or town, state) 4 W. 3rd St., Frederick, Md.			
PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.				DATE SIGNED 26 Feb 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1945		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar	
Name of Informant		Relationship		Address		City		State		Zip		Signature		Date		Time		Place		Signature		Date	
Jane Doe		Wife		123 Main St.		Baltimore		Md.		21201		J. Doe		Jan 15, 1945		11:00 AM		Home		J. Doe		Jan 15, 1945	
Name of Informant		Relationship		Address		City		State		Zip		Signature		Date		Time		Place		Signature		Date	
John Doe		Son		456 Oak St.		Baltimore		Md.		21201		J. Doe		Jan 15, 1945		12:00 PM		Home		J. Doe		Jan 15, 1945	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1871

CERTIFICATE OF DEATH

Reg. Dist. No.

01902

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. LENGTH OF STAY IN 1b <u>ENROUTE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> 06x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>T. FREDERICK MEMORIAL HOSP</u>		d. STREET ADDRESS <u>MAIN ST</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET E. WHITEHILL</u>		4. DATE OF DEATH <u>FEB. 2 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>10 APR. 1888</u>	9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEWING FACTORY</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>JOHN WHITEHILL</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN BARNES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-1724</u>	
17. INFORMANT <u>J. R. BARNES, WESTMINSTER, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>intermittent heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 2, 1958</u> to <u>Jan 2, 1959</u> , that I last saw the deceased alive on <u>Feb 2, 1959</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V Chase</u>		ADDRESS (Street, city or town, state) <u>4 E. Church St</u>	
PHYSICIAN'S NAME (Type) <u>Henry V Chase</u>		DATE SIGNED <u>2/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Hartzler</u>		ADDRESS <u>Union Bridge Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G238 2-16-59 et

1901

CERTIFICATE OF DEATH

Reg. Dist. No.

01903

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foxville near				c. LENGTH OF STAY IN 1b 25 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz RD 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Winfield Middle Last			4. DATE OF DEATH February 4 19 59 Month Day Year				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 21, 1888		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Winfield				14. MOTHER'S MAIDEN NAME Ellen King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 219-12-0169		INFORMANT Mrs. Scott Fritz		Address New Windsor, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sensitized Rheumatic CVD DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ± 3 days - ? years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Shunt 2/3/59						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan 2, 1959 to Jan 24, 1959 at I last saw the deceased alive on Feb 3, 1959 and that death occurred at 3:45 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas C. Love M.D.		ADDRESS (City, town, or state) Thurmont		DATE SIGNED 2/5/59		PHYSICIAN'S NAME (Type) Thomas Love	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-59		22c. NAME OF CEMETERY OR CREMATORY Beaver Dam Cem.		22d. LOCATION (City, town, or county) (State) near Union Bridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager ADDRESS Thurmont, Md.				24a. REC'D BY REGISTRAR FEB 9 1959 DATE		24b. REGISTRAR'S SIGNATURE L. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1901

Frederick

Maryland

Greensboro

Frederick

25 yrs.

Wife

MD 1

Charles

Wife

February 8

Male - white

July 21, 1888

70

Married

Retired

Maryland

U.S.A.

Thomas Winfield

Ellen King

MD 1

219-12-1100

Mrs. Scott E. King

New Windsor, Md.

Thomas Love

Married

2-7-10

Beaver Dam, Tenn.

near Union Bridge, Md.

and E. C. Cresser

Townsend, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01904

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK	
c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 South Market St.		d. STREET ADDRESS 128, South Market St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RALPH Middle VICTOR Last YOUNG		4. DATE OF DEATH Month February Day 9, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1874
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Pharmacist	
11. BIRTHPLACE (State or foreign country) Middletown Maryland.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Samuel Noah Young		14. MOTHER'S MAIDEN NAME Laura Virginia Herring	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-8460	
17. INFORMANT Address Mrs. Mary Lee Young 128, S. Market St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis, recurrent DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis, generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral pneumonia Jan. 59		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 24 , 19 59 , to Feb. 9 , 19 59 , that I last saw the deceased alive on Feb. 8 , 19 59 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick Shopping Center, Frederick, Md. DATE SIGNED Feb 11 '59			
ACTUAL SIGNATURE Ralph L. Michels M.D.			
PHYSICIAN'S NAME (Type) Ralph L. Michels, MD.			
22a. BURIAL, CREMATION, REMOVAL (Type) BURIAL		22b. DATE THEREOF 2/11/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE R. W. Walker ADDRESS FREDERICK, Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '59	
		24b. REGISTRAR'S SIGNATURE Charles S. Brown	

CERTIFICATE OF DEATH

<p>1. Name of deceased: John J. Jones</p>		<p>2. Sex: Male</p>	
<p>3. Age: 65</p>		<p>4. Date of birth: 1900</p>	
<p>5. Place of birth: Johns Hopkins, Baltimore, Md.</p>		<p>6. Date of death: 1965</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Immediate cause: Myocardial infarction</p>	
<p>9. Duration of illness: 2 weeks</p>		<p>10. Date of admission to hospital: 1965</p>	
<p>11. Name of attending physician: Dr. J. H. Smith</p>		<p>12. Name of hospital: Johns Hopkins Hospital</p>	
<p>13. Name of funeral home: Johns Hopkins Funeral Home</p>		<p>14. Name of cemetery: Greenwood Cemetery</p>	
<p>15. Name of informant: John J. Jones</p>		<p>16. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>17. Signature of informant: [Signature]</p>		<p>18. Signature of physician: [Signature]</p>	
<p>19. Date of completion: 1965</p>		<p>20. Place of completion: Baltimore, Md.</p>	